AUTHENTICATED
U.S. GOVERNMENT
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Calendar No. 609

106TH CONGRESS
2D SESSION

S. 2753

To amend title XVIII of the Social Security Act to provide a prescription drug benefit for the aged and disabled under the medicare program, to enhance the preventive benefits covered under such program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 19, 2000

Mr. DASCHLE (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. AKAKA, Mr. BAUCUS, Mr. BIDEN, Mr. BINGAMAN, Mrs. BOXER, Mr. BRYAN, Mr. BYRD, Mr. CLELAND, Mr. DODD, Mr. DORGAN, Mr. DURBIN, Mrs. FEINSTEIN, Mr. GRAHAM, Mr. HARKIN, Mr. HOLLINGS, Mr. INOUYE, Mr. JOHNSON, Mr. KERRY, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mrs. LINCOLN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. SARBANES, Mr. SCHUMER, and Mr. WELLSTONE) introduced the following bill; which was read twice and ordered placed on the calendar

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A BILL

To amend title XVIII of the Social Security Act to provide a prescription drug benefit for the aged and disabled under the medicare program, to enhance the preventive benefits covered under such program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Expansion for Needed Drugs (MEND) Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Prescription drug coverage was not a standard part of health insurance when the medicare program under title XVIII of the Social Security Act was enacted in 1965. Since 1965, however, drug coverage has become a key component of most private and public health insurance coverage, except for the medicare program.

(2) At least ⅔ of medicare beneficiaries have unreliable, inadequate, or no drug coverage at all.

(3) Seniors who do not have drug coverage typically pay, at a minimum, 15 percent more than people with coverage.

(4) Medicare beneficiaries at all income levels lack prescription drug coverage, with more than ½ of such beneficiaries having incomes greater than 150 percent of the poverty line.

(5) The number of private firms offering retiree health coverage is declining.

(6) Medigap premiums for drugs are too expensive for most beneficiaries and are highest for older senior citizens, who need prescription drug coverage the most and typically have the lowest incomes.

(7) The management of a medicare prescription drug benefit should mirror the practices employed by

private entities in delivering prescription drugs. Discounts should be achieved through competition.

(8) All medicare beneficiaries should have access to a voluntary, reliable, affordable outpatient drug benefit as part of the medicare program that assists with the high cost of prescription drugs and protects them against excessive out-of-pocket costs.

(9) The addition of a medicare drug benefit should be consistent with an overall plan to strengthen and modernize the medicare program.

TITLE I—PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 101. PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED

''ESTABLISHMENT OF PRESCRIPTION DRUG BENEFIT PROGRAM FOR THE AGED AND DISABLED

''SEC. 1860. (a) IN GENERAL.—There is established a voluntary insurance program to provide prescription drug benefits in accordance with the provisions of this part

for individuals who are aged or disabled or have end-stage renal disease and who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

''(b) NONINTERFERENCE.—In administering the prescription drug benefit program established under this part, the Secretary may not—

''(1) require a particular formulary or institute a price structure for benefits;

''(2) interfere in any way with negotiations between private entities and drug manufacturers, or wholesalers; or

''(3) otherwise interfere with the competitive nature of providing a prescription drug benefit through private entities.

''SCOPE OF BENEFITS

''SEC. 1860A. (a) IN GENERAL.—The benefits provided to an individual enrolled in the insurance program under this part shall consist of—

''(1) payments made, in accordance with the provisions of this part, for covered prescription drugs (as specified in subsection (b)) dispensed by any pharmacy participating in the program under this part (and, in circumstances designated by the private entity, by a nonparticipating pharmacy), in-

cluding any specifically named drug prescribed for the individual by a qualified health care professional regardless of whether the drug is included in a formulary established by the private entity if such drug is certified as medically necessary by such health care professional, up to the benefit limits specified in section 1860B; and

''(2) charging by pharmacies of the negotiated price—

''(A) for all covered prescription drugs, without regard to such benefit limit; and

''(B) established with respect to any drugs or classes of drugs described in subparagraphs (A) through (D) or (F) of section 1927(d)(2) that are available to individuals receiving benefits under this title.

''(b) COVERED PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Covered prescription drugs, for purposes of this part, include all prescription drugs (as defined in section 1860J(1)), including smoking cessation agents, except as otherwise provided in this subsection.

''(2) EXCLUSIONS FROM COVERAGE.—Covered prescription drugs shall not include drugs or classes of drugs described in subparagraphs (A) through

(D) and (F) through (H) of section 1927(d)(2) unless—

''(A) specifically provided otherwise by the Secretary with respect to a drug in any of such classes; or

''(B) a drug in any of such classes is certified to be medically necessary by a health care professional.

''(3) EXCLUSION OF PRESCRIPTION DRUGS TO THE EXTENT COVERED UNDER PART A OR B.—A drug prescribed for an individual that would otherwise be a covered prescription drug under this part shall not be so considered to the extent that payment for such drug is available under part A or B, including all injectable drugs and biologicals for which payment was made or should have been made by a carrier under section 1861(s)(2) (A) or (B) as of the date of enactment of the Medicare Expansion for Needed Drugs (MEND) Act of 2000. Drugs otherwise covered under part A or B shall be covered under this part to the extent that benefits under part A or B are exhausted.

''PAYMENT OF BENEFITS; BENEFIT LIMITS

''SEC. 1860B. (a) PAYMENT OF BENEFITS.—There shall be paid from the Prescription Drug Insurance Account within the Supplementary Medical Insurance Trust

Fund, in the case of each individual who is enrolled in the insurance program under this part and who purchases covered prescription drugs in a calendar year, an amount, not to exceed 50 percent of the applicable limit under subsection (b), equal to 50 percent of the negotiated price for each such covered prescription drug or such higher percentage as is proposed by a private entity pursuant to section 1860G(d)(7), if the Secretary finds that such percentage will not increase aggregate costs to the Prescription Drug Insurance Account.

''(b) BENEFIT LIMITS.—

''(1) CALENDAR YEARS 2002 THROUGH 2009.—For purposes of subsection (a), the limit under this subsection is—

''(A) for each of calendar years 2002, 2003, and 2004, $2,000;

''(B) for each of calendar years 2005, 2006, and 2007, $3,000;

''(C) for calendar year 2008, $4,000; and

''(D) for calendar year 2009, $5,000.

''(2) CALENDAR YEAR 2010 AND SUBSEQUENT YEARS.—For purposes of subsection (a), the limit under this subsection for calendar year 2010 and each subsequent calendar year is equal to the greater of—

''(A) the limit for the preceding year adjusted by the percentage change in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the preceding year; or

''(B) the limit for the preceding year.

''ELIGIBILITY AND ENROLLMENT

''SEC. 1860C. (a) ELIGIBILITY.—Every individual who, in or after 2002, is entitled to hospital insurance benefits under part A or enrolled in the medical insurance program under part B is eligible to enroll, in accordance with the provisions of this section, in the insurance program under this part, during an enrollment period prescribed in or under this section, in such manner and form as may be prescribed by regulations.

''(b) ENROLLMENT.—

''(1) IN GENERAL.—Each individual who satisfies subsection (a) shall be enrolled (or eligible to enroll) in the program under this part in accordance with the provisions of section 1837, as if that section applied to this part, except as otherwise explicitly provided in this part.

''(2) SINGLE ENROLLMENT PERIOD.—Except as provided in section 1837(i) (as such section applies to this part), 1860E, or 1860H, or as otherwise explicitly provided, no individual shall be entitled to

enroll in the program under this part at any time after the initial enrollment period.

''(3) SPECIAL ENROLLMENT PERIOD FOR 2002.—

''(A) IN GENERAL.—An individual who first satisfies subsection (a) in 2002 may, at any time on or before December 31, 2002—

''(i) enroll in the program under this part; and

''(ii) enroll or reenroll in such program after having previously declined or terminated enrollment in such program.

''(B) EFFECTIVE DATE OF COVERAGE.—An individual who enrolls under the program under this part pursuant to subparagraph (A) shall be entitled to benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as otherwise provided in this part, an individual's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—In addition to the causes of termination specified in section 1838, an individual's coverage under this part shall be terminated when the individual retains coverage under neither the program under part A nor the program under part B, effective on the effective date of termination of coverage under part A or (if later) under part B.

''PREMIUMS

''SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF MONTHLY PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of 2001 and of each succeeding year, determine and promulgate a monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

''(A) DETERMINATION OF ANNUAL BENEFIT COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits that will be payable from the Prescription Drug Insurance Account for prescription drugs dispensed in such calendar year with respect to enrollees in the program under this part. In calculating such

amount, the Secretary shall include an appropriate amount for a contingency margin.

''(B) DETERMINATION OF MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The Secretary shall determine the monthly premium rate with respect to such enrollees for such succeeding year, which shall be 1/12 of the share specified in clause (ii) of the amount determined under subparagraph (A), divided by the total number of such enrollees, and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) ENROLLEE AND EMPLOYER PERCENTAGE SHARES.—The share specified in this clause, for purposes of clause (i), shall be—

''(I) one-half, in the case of premiums paid by an individual enrolled in the program under this part; and

''(II) two-thirds, in the case of premiums paid for such an individual by a former employer (as defined in section 1860H(f)(2)).

''(3) PUBLICATION OF ASSUMPTIONS.—The Secretary shall publish, together with the promulgation of the monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

''(b) PAYMENT OF PREMIUMS.—

''(1) PAYMENTS BY DEDUCTION FROM SOCIAL SECURITY, RAILROAD RETIREMENT BENEFITS, OR BENEFITS ADMINISTERED BY OPM.—

''(A) DEDUCTION FROM BENEFITS.—In the case of an individual who is entitled to or receiving benefits as described in subsection (a), (b), or (d) of section 1840, premiums payable under this part shall be collected by deduction from such benefits at the same time and in the same manner as premiums payable under part B are collected pursuant to section 1840.

''(B) TRANSFERS TO PRESCRIPTION DRUG INSURANCE ACCOUNT.—The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer premiums collected pursuant to subparagraph (A) to the Prescription Drug Insurance Account from the

appropriate funds and accounts described in subsections (a)(2), (b)(2), and (d)(2) of section 1840, on the basis of the certifications described in such subsections. The amounts of such transfers shall be appropriately adjusted to the extent that prior transfers were too great or too small.

''(2) DIRECT PAYMENTS TO SECRETARY.—

''(A) ADDITIONAL PAYMENT BY ENROLLEE.—An individual to whom paragraph (1) applies (other than an individual receiving benefits as described in section 1840(d)) and who estimates that the amount that will be available for deduction under such paragraph for any premium payment period will be less than the amount of the monthly premiums for such period may (under regulations) pay to the Secretary the estimated balance, or such greater portion of the monthly premium as the individual chooses.

''(B) PAYMENTS BY OTHER ENROLLEES.—An individual enrolled in the insurance program under this part with respect to whom none of the preceding provisions of this subsection applies (or to whom section 1840(c) applies) shall

pay premiums to the Secretary at such times and in such manner as the Secretary shall by regulations prescribe.

''(C) DEPOSIT OF PREMIUMS.—Amounts paid to the Secretary under this paragraph shall be deposited in the Treasury to the credit of the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund.

''(c) CERTAIN LOW-INCOME INDIVIDUALS.—For rules concerning premiums for certain low-income individuals, see section 1860E.

''PRESCRIPTION DRUG INSURANCE ACCOUNT

''SEC. 1860F. (a) ESTABLISHMENT.—There is created within the Federal Supplemental Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Insurance Account' (in this section referred to as the 'Account').

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Account shall consist of—

''(A) such amounts as may be deposited in, or appropriated to, such fund as provided in this part; and

''(B) such gifts and bequests as may be made as provided in section 201(i)(1).

''(2) SEPARATION OF FUNDS.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplemental Medical Insurance Trust Fund.

''(c) PAYMENTS FROM ACCOUNT.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''ADMINISTRATION OF BENEFITS

''SEC. 1860G. (a) IN GENERAL.—The Secretary shall provide for administration of the benefits under this part through a contract with a private entity designated in accordance with subsection (c), for enrolled individuals residing in each service area designated pursuant to subsection (b) (other than such individuals enrolled in a Medicare+Choice program under part C), in accordance with the provisions of this section.

''(b) DESIGNATION OF SERVICE AREAS.—

''(1) IN GENERAL.—The Secretary shall divide the total geographic area served by the programs under this title into at least 15 service areas for purposes of administration of benefits under this part.

''(2) CONSIDERATIONS.—In determining or adjusting the number and boundaries of service areas

under this subsection, the Secretary shall seek to ensure that—

''(A) there is a reasonable level of competition among entities eligible to contract to administer the benefit program under this section for each area;

''(B) the designation of areas is consistent with the goal of securing contracts under this section with respect to the maximum feasible number of areas so designated; and

''(C) the designation of areas will foster the existence of a sufficient number of entities that are eligible and willing to administer the benefits under this part.

''(c) DESIGNATION OF PRIVATE ENTITY.—

''(1) AWARD AND DURATION OF CONTRACT.—

''(A) COMPETITIVE AWARD.—Each contract for a service area shall be awarded competitively in accordance with section 5 of title 41, United States Code, for a period (subject to subparagraph (B)) of not less than 2 nor more than 5 years.

''(B) REVIEW.—A contract for a service area shall be subject to an evaluation after 2 years.

''(2) ELIGIBLE PRIVATE ENTITIES.—A private entity eligible for consideration as a private entity responsible for administering the prescription drug benefit program under this part in a service area shall meet at least the following criteria:

''(A) TYPE.—The private entity shall be capable of administering a prescription drug benefit program, and may be a prescription drug vendor, wholesale and retail pharmacist delivery system, health care provider or insurer, any other type of entity as the Secretary may specify, or a consortium of such entities.

''(B) PERFORMANCE CAPABILITY.—The entity shall have sufficient expertise, personnel, and resources to perform effectively the benefit administration functions for such area.

''(C) FINANCIAL INTEGRITY.—The entity and its officers, directors, agents, and managing employees shall have a satisfactory record of professional competence and professional and financial integrity, and the entity shall have adequate financial resources to perform services under the contract without risk of insolvency.

''(3) PROPOSAL REQUIREMENTS.—

''(A) IN GENERAL.—An entity's proposal for award or renewal of a contract under this section shall include such material and information as the Secretary may require.

''(B) SPECIFIC INFORMATION.—A proposal described in subparagraph (A) shall include a detailed description of—

''(i) the schedule of negotiated prices that will be charged to enrollees;

''(ii) how the entity will deter medical errors that are related to prescription drugs; and

''(iii) proposed contracts with local pharmacy providers designed to ensure access, including compensation for local pharmacists' services.

''(4) EXCEPTIONS TO CONFLICT OF INTEREST RULES.—In awarding contracts under this subsection, the Secretary may waive conflict of interest rules generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the purposes of the programs under this title and the best interests of enrolled individuals; and

''(B) will permit a sufficient level of competition for such contracts, promote efficiency of benefits administration, or otherwise serve the objectives of the program under this part.

''(5) MAXIMIZING COMPETITION.—In awarding contracts under this section, the Secretary shall give consideration to the need to maintain sufficient numbers of entities eligible and willing to administer benefits under this part to ensure vigorous competition for such contracts.

''(d) FUNCTIONS OF PRIVATE ENTITY.—The private entity for a service area shall (or in the case of the function described in paragraph (7), may) perform the following functions:

''(1) PARTICIPATION AGREEMENTS, PRICES, AND FEES.—

''(A) PRIVATELY NEGOTIATED PRICES.—Each private entity shall establish, through negotiations with drug manufacturers and wholesalers and pharmacies, a schedule of prices for covered prescription drugs.

"(B) AGREEMENTS WITH PHARMACIES.—Each private entity shall enter into participation agreements under subsection (e) with pharmacies, that include terms that—

"(i) secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access); and

"(ii) permit the participation of any pharmacy in the service area that meets the participation requirements described in subsection (e).

"(C) LISTS OF PRICES AND PARTICIPATING PHARMACIES.—Each private entity shall ensure that the negotiated prices established under subparagraph (A) and the list of pharmacies with agreements under subsection (e) are regularly updated and readily available in the service area to health care professionals authorized to prescribe drugs, participating pharmacies, and enrolled individuals.

"(2) PAYMENT AND COORDINATION OF BENEFITS.—

"(A) PAYMENT.—Each private entity shall—

"(i) administer claims for payment of benefits under this part;

"(ii) determine amounts of benefit payments to be made; and

"(iii) receive, disburse, and account for funds used in making such payments, including through the activities specified in the provisions of this paragraph.

"(B) COORDINATION.—Each private entity shall coordinate with the Secretary, other private entities, pharmacies, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals, including coordination of access to and payment for covered prescription drugs according to an individual's in-service area plan provisions, when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

"(C) EXPLANATION OF BENEFITS.—Each private entity shall furnish to enrolled individuals an explanation of benefits in accordance with section 1806(a), and a notice of the balance of benefits remaining for the current year, whenever prescription drug benefits are pro-

vided under this part (except that such notice need not be provided more often than monthly).

''(3) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE.—Each private entity shall have in place effective cost and utilization management, quality assurance measures, and systems to reduce medical errors, including at least the following, together with such additional measures as the Secretary may specify:

''(A) DRUG UTILIZATION REVIEW.—A drug utilization review program conforming to the standards provided in section 1927(g)(2) (with such modifications as the Secretary finds appropriate).

''(B) FRAUD AND ABUSE CONTROL.—Activities to control fraud, abuse, and waste.

''(4) EDUCATION AND INFORMATION ACTIVITIES.—Each private entity shall have in place mechanisms for disseminating educational and informational materials to enrolled individuals and health care providers designed to encourage effective and cost-effective use of prescription drug benefits and to ensure that enrolled individuals understand their rights and obligations under the program.

''(5) BENEFICIARY PROTECTIONS.—

''(A) CONFIDENTIALITY OF HEALTH INFORMATION.—Each private entity shall have in effect systems to safeguard the confidentiality of health care information on enrolled individuals, which comply with section 1106 and with section 552a of title 5, United States Code, and meet such additional standards as the Secretary may prescribe.

''(B) GRIEVANCE AND APPEAL PROCEDURES.—Each private entity have in place such procedures as the Secretary may specify for hearing and resolving grievances and appeals brought by enrolled individuals against the private entity or a pharmacy concerning benefits under this part, which shall, to the extent the Secretary finds necessary and appropriate, include procedures equivalent to those specified in subsections (f) and (g) of section 1852.

''(6) RECORDS, REPORTS, AND AUDITS OF PRIVATE ENTITIES.—

''(A) RECORDS AND AUDITS.—Each private entity shall maintain adequate records, and afford the Secretary access to such records (including for audit purposes).

''(B) REPORTS.—Each private entity shall make such reports and submissions of financial and utilization data as the Secretary may require taking into account standard commercial practices.

''(7) PROPOSAL FOR ALTERNATIVE COINSURANCE AMOUNT.—

''(A) SUBMISSION.—Each private entity may submit a proposal for increased Government cost-sharing for generic prescription drugs, prescription drugs on the private entity's formulary, or prescription drugs obtained through mail order pharmacies.

''(B) CONTENTS.—The proposal submitted under subparagraph (A) shall contain evidence that such increased cost-sharing would not result in an increase in aggregate costs to the Account, including an analysis of differences in projected drug utilization patterns by beneficiaries whose cost-sharing would be reduced under the proposal and those making the cost-sharing payments that would otherwise apply.

''(8) OTHER REQUIREMENTS.—Each private entity shall meet such other requirements as the Secretary may specify.

''(e) PHARMACY PARTICIPATION AGREEMENTS.—

''(1) IN GENERAL.—A pharmacy that meets the requirements of this subsection shall be eligible to enter an agreement with a private entity to furnish covered prescription drugs and pharmacists' services to enrolled individuals residing in the service area.

''(2) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and requirements:

''(A) LICENSING.—The pharmacy and pharmacists shall meet (and throughout the contract period will continue to meet) all applicable State and local licensing requirements.

''(B) LIMITATION ON CHARGES.—Pharmacies participating under this part shall not charge an enrolled individual more than the negotiated price for an individual drug as established under subsection (d)(1), regardless of whether such individual has attained the benefit limit under section 1860B(b), and shall not charge an enrolled individual more than the individual's share of the negotiated price as determined under the provisions of this part.

"(C) PERFORMANCE STANDARDS.—The pharmacy shall comply with performance standards relating to—

"(i) measures for quality assurance, reduction of medical errors, and participation in the drug utilization review program described in subsection (d)(3)(A);

"(ii) systems to ensure compliance with the confidentiality standards applicable under subsection (d)(5)(A); and

"(iii) other requirements as the Secretary may impose to ensure integrity, efficiency, and the quality of the program.

"(f) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG PRIVATE ENTITIES.—During the period after the Secretary has given notice of intent to terminate a contract with a private entity, the Secretary may transfer responsibilities of the private entity under such contract to another private entity.

"(g) SPECIAL ATTENTION TO RURAL AND HARD-TO-SERVE AREAS.—

"(1) IN GENERAL.—The Secretary shall ensure that all beneficiaries have access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and

delivery in rural and hard-to-serve areas (as the Secretary may define by regulation).

''(2) SPECIAL ATTENTION DEFINED.—For purposes of paragraph (1), the term 'special attention' may include bonus payments to retail pharmacists in rural areas, extra payments to the private entity for the cost of rapid delivery of pharmaceuticals, and any other actions the Secretary determines are necessary to ensure full access to rural and hard-to-serve beneficiaries.

''(3) GAO REPORT.—Not later than 2 years after the implementation of this part the Comptroller General of the United States shall submit to Congress a report on the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in rural and hard-to-serve areas under this part together with any recommendations of the Comptroller General regarding any additional steps the Secretary may need to take to ensure the access of medicare beneficiaries to pharmaceuticals and pharmacists' services in such areas under this part.

''(h) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary is authorized to include in a contract awarded under subsection (c) such incentives for cost and utilization manage-

ment and quality improvement as the Secretary may deem appropriate, including—

''(1) bonus and penalty incentives to encourage administrative efficiency;

''(2) incentives under which private entities share in any benefit savings achieved;

''(3) risk-sharing arrangements related to benefit payments; and

''(4) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization.

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860H. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section called the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals and to maintain such existing benefit programs, by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified re-

tiree prescription drug plan (as defined in subsection (f)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the insurance benefit under this part.

''(2) OTHER REQUIREMENTS.—The sponsor shall provide such information, and comply with such requirements, including information requirements to ensure the integrity of the program, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENT.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined as described in paragraph (2), for each retired individual (or spouse) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for but was not enrolled in the insurance program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to ⅔ of the monthly premium amount payable by an enrolled individual, as set for the calendar year pursuant to section 1860D(a)(2).

''(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) PART D ENROLLMENT FOR CERTAIN INDIVIDUALS COVERED BY EMPLOYMENT-BASED RETIREE HEALTH COVERAGE PLANS.—

''(1) ELIGIBLE INDIVIDUALS.—An individual shall be given the opportunity to enroll in the program under this part during the period specified in paragraph (2) if—

''(A) the individual declined enrollment in the program under this part at the time the individual first satisfied section 1860C(a);

''(B) at that time, the individual was covered under a qualified retiree prescription drug plan for which an incentive payment was paid under this section; and

''(C)(i) the sponsor subsequently ceased to offer such plan; or

''(ii) the value of prescription drug coverage under such plan became less than the value of the coverage under the program under this part.

''(2) SPECIAL ENROLLMENT PERIOD.—An individual described in paragraph (1) shall be eligible to enroll in the program under this part during the 6-month period beginning on the first day of the month in which—

''(A) the individual receives a notice that coverage under such plan has terminated (in the circumstance described in paragraph (1)(C)(i)) or notice that a claim has been denied because of such a termination; or

''(B) the individual received notice of the change in benefits (in the circumstance described in paragraph (1)(C)(ii)).

''(f) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(2) EMPLOYER.—The term 'employer' has the meaning given to such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value to each retired beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' by section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS

''SEC. 1860I. (a) IN GENERAL.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Prescription Drug Insurance Account, a Government contribution equal to—

''(1) the aggregate premiums payable for a month pursuant to section 1860D(a)(2) by individuals enrolled in the program under this part; plus

''(2) one-half the aggregate premiums payable for a month pursuant to such section for such individuals by former employers.

''(b) APPROPRIATIONS TO COVER INCENTIVES FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—There are authorized to be appropriated to the Prescription Drug Insurance Account from time to time, out of any moneys in the Treasury not otherwise appropriated such sums as may be necessary for payment of incentive payments under section 1860H(c).

''PRESCRIPTION DRUG DEFINED

''SEC. 1860J. As used in this part, the term 'prescription drug' means—

''(1) a drug that may be dispensed only upon a prescription, and that is described in subpara-

graph (A)(i), (A)(ii), or (B) of section 1927(k)(2); and

''(2) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act, and needles, syringes, and disposable pumps for the administration of such insulin.''.

(b) STUDY OF ANNUAL OPEN ENROLLMENT.—

(1) STUDY.—During 2002 and 2003, the Secretary shall conduct a study on the feasibility and advisability of establishing an annual open enrollment period for the program under part D (as added by subsection (a)). Such study shall reflect data reported by private entities administering benefits under such part and shall include—

(A) a review of the costs, effectiveness, and administrative feasibility of an annual open enrollment period for beneficiaries who—

(i) previously declined enrollment; or

(ii) who previously disenrolled and desire to reenroll;

(B) an evaluation of a premium penalty for late enrollment based on actuarially determined costs to the program of late enrollment; and

(C) a projection of the costs if open enrollment was allowed without a penalty.

(2) REPORT.—The Secretary shall prepare a report setting forth the outcome of the study and may include in the report a recommendation as to whether an annual open enrollment period should be implemented under such part.

(c) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO FEDERAL SUPPLEMENTARY HEALTH INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(A) in the last sentence of subsection (a)—

(i) by striking ''and'' after ''section 201(i)(1)''; and

(ii) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Insurance Account established by section 1860F'';

(B) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund),'';

(C) in the first sentence of subsection (h), by inserting before the period the following: ''and section 1860D(b)(4) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''; and

(D) in the first sentence of subsection (i)—

(i) by striking ''and'' after ''section 1840(b)(1)''; and

(ii) by inserting before the period the following: '', section 1860D(b)(2) (in which case the payments shall come from the Prescription Drug Insurance Account in the Supplementary Medical Insurance Trust Fund)''.

(2) PRESCRIPTION DRUG OPTION UNDER MEDICARE+CHOICE PLANS.—

(A) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(i) in subsection (a)(1)(A), by striking ''parts A and B'' inserting ''parts A, B, and D''; and

(ii) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(B) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of such Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(C) ACCESS TO SERVICES.—Section 1852(d)(1) of such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(F) the plan for prescription drug benefits under part D guarantees coverage of any specifically named covered prescription drug for an enrollee, when prescribed by a physician in accordance with the provisions of such part, regardless of whether such drug would otherwise

be covered under an applicable formulary or discount arrangement.''.

(D) PAYMENTS TO ORGANIZATIONS.—Section 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(i) by inserting ''determined separately for benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(ii) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(iii) by inserting before the last sentence the following: ''In the case of the payments for benefits under part D, such payment shall initially be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate. By 2006, the adjustments would be for the same risk factors applicable for benefits under parts A and B.''.

(E) CALCULATION OF ANNUAL MEDICARE +CHOICE CAPITATION RATES.—Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate'';

(ii) in paragraph (6)(A), by striking ''rate of growth in expenditures under this title'' and inserting ''rate of growth in expenditures for benefits available under parts A and B''; and

(iii) by adding at the end the following new paragraph:

''(8) PAYMENT FOR PRESCRIPTION DRUGS.—The Secretary shall determine a capitation rate for prescription drugs—

''(A) dispensed in 2002, which is based on the projected national per capita costs for prescription drug benefits under part D and associated claims processing costs for beneficiaries under the original medicare fee-for-service program; and

''(B) dispensed in each subsequent year, which shall be equal to the rate for the previous year updated by the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual enrolled under part D.''.

(F) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PROVISION OF PART D BENEFITS.—In no event may a Medicare+Choice organization include as part of a plan for prescription drug benefits under part D a requirement that an enrollee pay a deductible, or a coinsurance percentage that exceeds 50 percent.''.

(G) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of such Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for benefits under parts A and B and for prescription drug benefits under part D.''.

(H) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d)

is amended by adding at the end the following new paragraph:

''(6) AVAILABILITY OF NEGOTIATED PRICES.—Each contract under this section shall provide that enrollees who exhaust prescription drug benefits under the plan will continue to have access to prescription drugs at negotiated prices equivalent to the total combined cost of such drugs to the plan and the enrollee prior to such exhaustion of benefits.''.

(3) EXCLUSIONS FROM COVERAGE.—

(A) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(B) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (H), by striking ''and'' at the end;

(ii) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(J) in the case of prescription drugs covered under part D, which are not prescribed in accordance with such part;''.

SEC. 102. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION DRUG COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) STATE OPTION TO BUY-IN DUALLY ELIGIBLE INDIVIDUALS.—

(1) COVERAGE OF PREMIUMS AS MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d) is amended in the second sentence of the flush matter at the end by striking ''premiums under part B'' the first place it appears and inserting ''premiums under parts B and D''.

(2) STATE COMMITMENT TO CONTINUE PARTICIPATION IN PART D AFTER BENEFIT LIMIT REACHED.—Section 1902(a) of such Act (42 U.S.C. 1396a) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65)(B) and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(66) provide that in the case of any individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost-sharing and for whom the State elects to pay premiums under part D of title XVIII pursuant to section 1860E, the State will purchase all prescription drugs for such individual in accordance with the provisions of such part D, without regard to whether the benefit limit for such individual under section 1860B(b) has been reached.''.

(b) MEDICARE COST-SHARING REQUIRED FOR QUALIFIED MEDICARE BENEFICIARIES.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

(C) by adding at the end the following new clause:

''(iii) premiums under section 1860D.''; and

(2) in subparagraph (D)—

(A) by inserting ''(i)'' after ''(D)''; and

(B) by adding at the end the following:

''(ii) The difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).''.

(c) MEDICARE DRUG COST-SHARING REQUIRED FOR MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BETWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

(1) DEFINITIONS OF ELIGIBLE BENEFICIARIES AND COVERAGE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(x)(1) The term 'qualified medicare drug beneficiary' means an individual—

''(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an

individual entitled to such benefits only pursuant to an enrollment under section 1818A);

''(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (p)(2)(D)) is above 100 percent but below 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

''(2) The term 'medicare drug cost-sharing' means the following costs incurred with respect to a qualified medicare drug beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

''(A) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is less than 135 percent of the official poverty line—

"(i) premiums under section 1860D; and

"(ii) the difference between the amount that is paid under section 1860B and the amount that would be paid under such section if any reference to '50 percent' therein were deemed a reference to '100 percent' (or, if the Secretary approves a higher percentage under such section, if such percentage were deemed to be 100 percent).

"(B) In the case of a qualified medicare drug beneficiary whose income (as determined under paragraph (1)) is at least 135 percent but less than 150 percent of the official poverty line, a percentage of premiums under section 1860D, determined on a linear sliding scale ranging from 100 percent for individuals with incomes at 135 percent of such line to 0 percent for individuals with incomes at 150 percent of such line.

"(3) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.".

(2) STATE PLAN REQUIREMENT.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) in clause (iii), by striking ''and'' at the end; and

(B) by adding at the end the following new clause:

''(v) for making medical assistance available for medicare drug cost-sharing (as defined in section 1905(x)(2)) for qualified medicare drug beneficiaries described in section 1905(x)(1); and''.

(3) 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE DRUG COST-SHARING.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

''(7) except in the case of amounts expended for an individual whose eligibility for medical assistance is not limited to medicare or medicare drug cost-sharing, an amount equal to 100 percent of amounts as expended as medicare drug cost-sharing for quali-

fied medicare drug beneficiaries (as defined in section 1905(x)); plus''.

(d) MEDICAID DRUG PRICE REBATES UNAVAILABLE WITH RESPECT TO DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended by adding at the end the following new subsection:

''(l) DRUGS PURCHASED THROUGH MEDICARE BUY-IN.—The provisions of this section shall not apply to prescription drugs purchased under part D of title XVIII pursuant to an agreement with the Secretary under section 1860E (including any drugs so purchased after the limit under section 1860B(b) has been exceeded).''.

(e) AMENDMENTS TO MEDICARE PART D.—Part D of title XVIII of the Social Security Act (as added by section 2) is amended by inserting after section 1860D the following new section:

''SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT RULES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860E. (a) STATE AGREEMENTS FOR COVERAGE.—

''(1) IN GENERAL.—The Secretary shall, at the request of a State, enter into an agreement with the State under which all individuals described in paragraph (2) are enrolled in the program under this part, without regard to whether any such individual

has previously declined the opportunity to enroll in such program.

''(2) ELIGIBILITY GROUPS.—The individuals described in this paragraph, for purposes of paragraph (1), are individuals who satisfy section 1860C(a) and who are—

''(A)(i) eligible individuals within the meaning of section 1843; and

''(ii) in a coverage group or groups permitted under section 1843 (as selected by the State and specified in the agreement); or

''(B) qualified medicare drug beneficiaries (as defined in section 1905(v)(1)).

''(3) COVERAGE PERIOD.—The period of coverage under this part of an individual enrolled under an agreement under this subsection shall be as follows:

''(A) INDIVIDUALS ELIGIBLE (AT STATE OPTION) FOR PART B BUY-IN.—In the case of an individual described in subsection (a)(2)(A), the coverage period shall be the same period that applies (or would apply) pursuant to section 1843(d).

''(B) QUALIFIED MEDICARE DRUG BENEFICIARIES.—In the case of an individual described in subsection (a)(2)(B)—

''(i) the coverage period shall begin on the latest of—

''(I) January 1, 2002;

''(II) the first day of the third month following the month in which the State agreement is entered into; or

''(III) the first day of the first month following the month in which the individual satisfies section 1860C(a); and

''(ii) the coverage period shall end on the last day of the month in which the individual is determined by the State to have become ineligible for medicare drug cost-sharing.

''(b) SPECIAL PART D ENROLLMENT OPPORTUNITY FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In the case of an individual who—

''(1) satisfies section 1860C(a); and

''(2) loses eligibility for benefits under the State plan under title XIX after having been enrolled

under such plan or having been determined eligible for such benefits;

the Secretary shall provide an opportunity for enrollment under the program under this part during the period that begins on the date that such individual loses such eligibility and ends on the date specified by the Secretary.

''(c) DEFINITION.—For purposes of this section, the term 'State' has the meaning given such term under section 1101(a) for purposes of title XIX.''.

(f) REMOVAL OF SUNSET DATE FOR COST-SHARING IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALIFYING INDIVIDUALS.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv))is amended to read as follows—

''(iv) subject to section 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official pov-

erty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) RELOCATION OF PROVISION REQUIRING 100 PERCENT FEDERAL MATCHING OF STATE MEDICAL ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDIVIDUALS.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by subsection (c)(3), is amended—

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

''(8) an amount equal to 100 percent of amounts as expended as medicare drug cost-sharing for individuals described in section 1903(a)(10)(E)(iv); plus''.

(3) REPEAL OF SECTION 1933.—Section 1933 is repealed.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2002.

SEC. 103. CATASTROPHIC PRESCRIPTION DRUG COVERAGE BENEFIT.

(a) RECOMMENDATIONS WITH RESPECT TO A MEDICARE CATASTROPHIC DRUG BENEFIT.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives detailed recommendations on structuring a catastrophic drug benefit for medicare beneficiaries.

(2) RECOMMENDATIONS DESCRIBED.—The recommendations under paragraph (1) shall—

(A) ensure coverage of the costs of prescription drugs above a specified level of out-of-pocket expenditures;

(B) conform to the administrative structure established in this Act;

(C) have a projected cost that does not exceed the amounts described in subsection (b)(3)(A); and

(D) take effect no later than January 1, 2003.

(3) FINAL REGULATIONS.—

(A) IN GENERAL.—If legislation of a medicare catastrophic drug benefit is not enacted that meets the requirements of paragraph (2) by June 1, 2001, the Secretary of Health and Human Services shall promulgate final regulations containing such standards no later than January 1, 2002.

(B) CERTIFICATION BY OMB AND HCFA.—A final regulation promulgated by the Secretary under subparagraph (A) shall not take effect unless the Director of the Office of Management and Budget and the Chief Actuary of the Health Care Financing Administration certify that aggregate Federal expenses incurred in providing the catastrophic drug benefit under this section will not exceed $50,000,000,000 between fiscal years 2003 and 2010. If either certification is not provided, the Secretary shall submit a revised recommendation on structuring a catastrophic drug benefit to the appropriate committees of Congress under paragraph (1) no later than 30 days after the Secretary receives a notification that such certification will not be provided.

(b) CATASTROPHIC PRESCRIPTION DRUG COVERAGE RESERVE FUND.—

(1) ESTABLISHMENT OF RESERVE FUND.—There is established a reserve fund which shall be known as the ''Catastrophic Prescription Drug Coverage Reserve Fund'' (in this subsection referred to as the ''Reserve Fund'').

(2) AMOUNTS IN RESERVE FUND.—Subject to subparagraph (B), the Reserve Fund shall consist of such amounts as are appropriated to the Reserve Fund under paragraph (3).

(3) APPROPRIATION TO RESERVE FUND.—

(A) IN GENERAL.—

(i) FISCAL YEARS 2003 THROUGH 2010.—There are appropriated to the Reserve Fund for the period beginning with fiscal year 2003 and ending with fiscal year 2010, $50,000,000,000.

(ii) SUBSEQUENT FISCAL YEARS.—There are authorized to be appropriated to the Reserve Fund for each subsequent fiscal year, such sums as may be necessary to carry out the provisions of this section.

(B) AVAILABILITY.—Sums appropriated under subparagraph (A)(i) shall remain avail-

able, without fiscal year limitation, until expended.

SEC. 104. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS.

(a) REVISION OF MEDICARE COVERAGE FOR IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) (as amended by section 227(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1832 of the Social Security Act (42 U.S.C. 1395k) (as amended by section 227(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–354), as enacted into law by section 1000(a)(6) of Public Law 106–113) is amended—

(i) by striking subsection (b); and

(ii) by redesignating subsection (c) as subsection (b).

(B) Subsections (c) and (d) of section 227 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–355), as enacted into law by section 1000(a)(6) of Public Law 106–113, are repealed.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to drugs furnished on or after the date of enactment of this Act.

(b) EXTENSION OF CERTAIN SECONDARY PAYER REQUIREMENTS.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following: ''With regard to immunosuppressive drugs furnished on or after the date of enactment of the Medicare Expansion for Needed Drugs (MEND) Act of 2000, this subparagraph shall be applied without regard to any time limitation.''.

SEC. 105. GAO STUDY AND BIENNIAL REPORTS ON COMPETITION AND SAVINGS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the prescription drug benefit program under part D of the medicare program under title XVIII of the

Social Security Act (as added by this title), including an analysis of—

(1) the extent to which the competitive bidding process under such program fosters maximum competition and efficiency; and

(2) the savings to the medicare program resulting from such prescription drug benefit program, including the reduction in the number or length of hospital visits.

(b) INITIAL REPORT.—Not later than September 1, 2001, the Comptroller General shall submit to Congress a report on the extent to which the competitive bidding process under the prescription drug benefit program under part D of the medicare program under title XVIII of the Social Security Act (as added by this title) is expected to foster maximum competition and efficiency.

(c) BIENNIAL REPORTS.—Not later than January 1, 2004, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the results of the study conducted under this section, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

SEC. 106. MEDPAC STUDY AND ANNUAL REPORTS ON THE PHARMACEUTICAL MARKET, PHARMACIES, AND BENEFICIARY ACCESS.

(a) ONGOING STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall conduct an ongoing study and analysis of the prescription drug benefit program under part D of the Social Security Act (as added by this title), including an analysis of the impact of the prescription drug benefit program on—

(1) the pharmaceutical market, including costs and pricing of pharmaceuticals, beneficiary access to such pharmaceuticals, and trends in research and development;

(2) franchise, independent, and rural pharmacies; and

(3) beneficiary access to prescription drugs, including an assessment of—

(A) out-of-pocket spending;

(B) generic and brand-name utilization; and

(C) pharmacists' services.

(b) REPORT.—Not later than January 1, 2004, and annually thereafter, the Medicare Payment Advisory Commission shall submit to Congress a report on the results of the study conducted under this section, together with

any recommendations for legislation that such Commission determines to be appropriate as a result of such study.

TITLE II—ENHANCED MEDICARE PREVENTION PROGRAM

SEC. 201. MEDPAC BIENNIAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''and'' at the end;

(B) in subparagraph (D), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(E) by not later than January 1, 2002, and biennially thereafter, submit the report to Congress described in paragraph (7).''; and

(2) by adding at the end the following new paragraph:

''(7) EVALUATION OF ACTUARIAL EQUIVALENCE OF MEDICARE AND PRIVATE SECTOR BENEFIT PACKAGES.—

''(A) EVALUATION.—The Commission shall—

''(i) evaluate the benefit package offered under the medicare program under this title; and

''(ii) determine the degree to which such benefit package is actuarially equivalent to that offered by health benefit programs available in the private sector to individuals over age 65.

''(B) REPORT.—The Commission shall submit a report to Congress that shall contain—

''(i) a detailed statement of the findings and conclusions of the Commission regarding the evaluation conducted under subparagraph (A);

''(ii) the recommendations of the Commission regarding changes in the benefit package offered under the medicare program under this title that would keep the program modern and competitive in relation to health benefit programs available in the private sector; and

''(iii) the recommendations of the Commission for such legislation and ad-

ministrative actions as it considers appropriate.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 202. NATIONAL INSTITUTE ON AGING STUDY AND REPORT.

(a) STUDIES.—The Director of the National Institute on Aging shall conduct 1 or more studies focusing on ways to—

(1) improve quality of life for the elderly;

(2) develop better ways to prevent or delay the onset of age-related functional decline and disease and disability among the elderly; and

(3) develop means of assessing the long-term development of cost-effective benefits and cost-savings benefits for health promotion and disease prevention among the elderly.

(b) REPORT.—Not later than January 1, 2006, the Director of the National Institute on Aging shall submit a report to the Secretary regarding each study conducted under subsection (a) and containing a detailed statement of research findings and conclusions that are scientifically valid and are demonstrated to prevent or delay the onset of chronic illness or disability among the elderly.

(c) TRANSMISSION TO INSTITUTE OF MEDICINE.—Upon receipt of each report described in subsection (b), the Secretary shall transmit such report to the Institute of Medicine of the National Academy of Sciences for consideration in its effort to conduct the comprehensive study of current literature and best practices in the field of health promotion and disease prevention among the medicare beneficiaries described in section 204.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for fiscal years 2001 through 2006 to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until September 30, 2005.

SEC. 203. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among

medicare beneficiaries including the issues described in paragraph (2) and to submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each covered benefit is—

(i) medically effective; and

(ii) a cost-effective benefit or a cost-saving benefit;

(B) utilization of covered benefits (including any barriers to or incentives to increase utilization); and

(C) quality of life issues associated with both health promotion and disease prevention benefits covered under the medicare program and those that are not covered under such program that would affect all medicare beneficiaries.

(b) REPORT.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this section, and every fifth year thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed state-

ment of the findings and conclusions of the study conducted under subsection (a) and the recommendations for legislation described in paragraph (2).

(2) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the Partnership for Prevention, shall develop recommendations in legislative form that—

(A) prioritize the preventive benefits under the medicare program; and

(B) modify preventive benefits offered under the medicare program based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—On the day on which the report described in subsection (b) is submitted to the President, the President shall transmit the report and recommendations in legislative form described in subsection (b)(2) to Congress.

(2) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House of Representatives is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

SEC. 204. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that

House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 203(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section

203(b)(2), transmitted by the President to the House of Representatives and the Senate under section 203(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Calendar No. 609

106TH CONGRESS
2D SESSION

S. 2753

A BILL

To amend title XVIII of the Social Security Act to provide a prescription drug benefit for the aged and disabled under the medicare program, to enhance the preventive benefits covered under such program, and for other purposes.

JUNE 19, 2000

Read twice and ordered placed on the calendar